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ABSTRACT

Health care providers recognize the importance of standards of care and standardized models of evaluation and intervention on cases of domestic violence. Examined are algorithms and care pathways being utilized to assure consistency in the evaluation and interventions offered where the spectrum symptoms of domestic violence are identified in the course of counseling. A review of the literature on the use of treatment guidelines is offered, as are treatment and legal considerations and community resources available to the counselor. (Contains 16 references and 2 tables.) (Author)

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Algorithms and Care Pathways for Assessment and Counseling for Domestic Violence

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Key words: Domestic Violence, Care Pathways, Abuse Counseling

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Abstract

Health care providers recognize the importance of standards of care and standardized models of evaluation and intervention in cases of domestic violence. Examined are algorithms and care pathways being utilized to assure consistency in the evaluation and interventions offered where the spectrum symptoms of domestic violence are identified in the course of counseling. A review of the literature on the use of treatment guidelines is offered, as are treatment and legal considerations and community resources available to the counselor.

Introduction

Victims and survivors of domestic violence whether it involves child abuse, sibling abuse, spouse abuse, sexual assault or elderly abuse and neglect are seeking the assistance of family counselors and other health care professionals with an understanding and sensitivity to their needs and with the expectation that a standardized model of care and treatment will be provided. While each individual brings a unique and highly individualized case to the health care provider, the need for standardized models of care becomes essential to assure consistent standards of care for each person.

Health care providers have begun to utilize clinical algorithms and critical pathways in order to standardized the clinical care provided to individuals who are diagnosed and treated for domestic violence issues. Developments in the health care systems have driven important changes that have provided shifts in traditional paradigms of service to more clinically relevant and standardized approaches to assessment and intervention treatment. This article describes a model that includes algorithms and care pathways that have been developed and implemented in order to coordinate a standard approach to treatment for victims of domestic violence. The use of such treatment guidelines has gained considerable attention in the managed care arena among health care professionals (Griffith, 1999).

Literature Review

Practice guidelines have been guided by clinical research studies (Miller and Veltkamp, 1998). Which have identified the effects of victimization in cases of family violence. Cicchette and Olsen (1987) in the Harvard Maltreatment Project, realized that adult victims were often overcontrolled in their management of feelings and impulses during the victimization process and therefore significantly at risk for developing psychopathology (Walker, 1998). Among the most relevant characteristics of at-risk

individuals are children who: (1) have a history of family violence, abuse, or neglect; (2) have recognized family disorganization; (3) experience a lack of acceptance and a lack of interest on the part of the family of the victim; and (4) have poor quality of communication with others in and beyond the family (Veltkamp and Miller, 1990).

There is considerable evidence in the health care literature (Griffith, 1998, Sackett, 1997, Eddy, 1996) that the use of algorithms and care pathways based on clinical research will help in standardizing care and providing the necessary ingredients for effective diagnostic and counseling interventions. The goal is to make the client management guideline the accepted professional behavior and a reward in itself (Griffith, 1999). To the extent that this is successful, five components that occur: (1) the guideline is widely used and becomes habitual, (2) multidisciplinary professionals can use it to anticipate care events, (3) counselors can use it as a shorthand or outline to guide their decisions and their communications to others. The individual plan becomes the exception to the guideline, (4) the logistics for delivering the guideline components are convenient and reliable. Intermediate methods or strategies in the guideline must be readily available and delivered uniformly in terms of quality and timeliness, and (5) the guideline defines the measures of performance and incorporates information collection that can be used for its evaluation and improvement. The individualized plans counselors may use also contribute information for guideline revision.

Algorithms and Care Pathways for Counselors

Clinical algorithms and care pathways delineate specific timelines in which intervention should occur. They further address the decision-making process, the clinical services offered and the potential interactions among multi-disciplinary health care professionals and providers for specific needs of patients referred. Clinical information

systems capable of supporting the functional requirements of comprehensive critical pathway also provide direction to the development and implementation of algorithms appropriate for change (Miller and Veltkamp, 1996). The clinical algorithm for an abusive situation or for family violence is summarized in Figure 1. Sometimes the client will present with symptoms or complaints not of the abuse but of some other related symptomatology. The clinical algorithm moves through the history and systems review, the identification of symptoms and the diagnostic criteria for acute and/or chronic trauma. It also considers symptoms, specific treatment and supportive care, and how the counselors can reassess and monitor an abusive situation over time.

Figure 1

The care pathway delineates the specific timelines in which assessment and treatment or interventions must occur. Note with specificity the importance of the legal and ethical responsibilities within the abuse spectrum. Specific emphasis here is on reporting child and adult abuse to the appropriate local state Department of Social Services unit. In addition, specific information related to office management for clients who present with problems associated with domestic violence are summarized in Figure 2, the care pathway or guideline for domestic violence. These become the critical ingredients to be considered in a care pathway that would provide standardized care and treatment for the victim of domestic violence and abuse.

Figure 2

Assessing Domestic Violence

The presence of depression in traumatized victims of abuse has been well-documented (Conte, Berlinger, Schwerman, 1987; Russell, 1983; Veltkamp & Miller, 1994). The protracted depression is reported as a most common symptom along with aggravated depressive symptoms, hyperarousal, intrusive thoughts, insomnia, psychosomatic symptomatology, and dissociation commonly associated with the post traumatized period. The paralysis of apathy and helplessness, the intense internalized anger, the debased self-image, and ruminations of guild, all are recognized within the cluster of depressive symptomatology frequently recognized in victims of prolonged abuse.

Long-term traumatized individuals who have been abused (Horowitz & Soloman, 1978; Frayberg, 1980) show anxiety, agitation and hypervigilance which is most recognized not only in their insomnia and startle reactions, but also in tension headaches, abdominal pain, gastrointestinal disturbances, and other forms of somatization. Victims of prolonged trauma are as well users of the art of altered consciousness as a means of coping and controlling the situation and the perpetrator. Through dissociative experiences, including suppression and denial, they are able to cope through the immediacy of the trauma but often suffer at later times from disturbances of memory and concentration because of their conditioned experience to the dissociative form of coping. Adult survivors of child sexual abuse and adult victims of domestic violence use these dissociative capacities in their adaptation and accommodation to stressful life experiences.

Victims of domestic violence and sexual abuse (Miller & Veltkamp, 1996) may well experience a more complex picture of psychopathology. They are, in fact, victims of a disorder of extreme stress which must capture the manifestations of repeated and

prolonged abuse and its resultant impact on personality development that is not usually seen in situations of more acute stressful nature. Counselors have come to the realization that the significance of prolonged and repeated traumatization as seen through domestic violence and physical and sexual abuse warrant careful consideration in providing a counseling intervention.

Domestic violence in its many forms has become the focus of considerable concern. More than one million abused women and children seek medical attention for injuries caused by male spouses each year. Some studies suggest that at least 20% of the visits to emergency rooms involve maltreatment or abuse. Current estimates are that one-third of all married couples engage in spousal assault and the number of women and children who are objects of such assault is close to 2 million per year (National Center for Child Abuse & Neglect, 1996).

There are two national epidemiological surveys (National Center for Child Abuse and Neglect, 1996) which have convincing evidence that domestic violence is occurring at alarmingly high rates. Most family counselors believe that spouse and child abuse tends to be underreported and, to date, the data on spouse and child abuse remains only begins to identify the spectrum of abusive situations that need the attention of family counselors.

Addressed are the difficulties and complexities in understanding and diagnosing family violence. While the majority of post-traumatic stress disorder cases reported in literature are related to veterans exposed to combat experience, there is a growing recognition that the presence of family violence, including child and spouse abuse, can cause symptoms associated with PTSD (Miller & Fiebelman, 1989).

Risk Factors in Domestic Violence

Counselor recognition of "at risk" factors is crucial. The "at-risk" factors in domestic violence focus on two elements: (1) a multigenerational pattern of abuse, and (2) a family constellation of "at-risk" factors as reflected in the "victim-victimization" spectrum. Multigenerational patterns of abuse on to subsequent generations, perpetuating a "cycle of violence" (Walker, 1996). Persons most prone to violent behavior experience financial problems, frequent moves, substance abuse, and isolation from peer groups and family support systems, which often include ingredients that leads to family violence. Efforts to recognize "high-risk" individuals and to provide early intervention in the form of prevention and education may be of considerable benefit in reducing spouse and child abuse in all segments of the population. Table 1 identified as the victim-victimizer spectrum summarizes risk factors for both the victim and the perpetrator.

Table 1

In addition to the factors identified in the "victim-victimizer" spectrum, the family constellation of at-risk factors in abusing families may include the following characteristics:

- One parent may be extremely passive, dependent, and/or reluctant to assert self for destroying the family unit.
- Poor marital relationship, a lack of constructive communication or poor interpersonal relationship.
- The perpetrator turns outside the family or towards the child to relieve and displace emotional tension and stress.

- The child may feel emotionally deprived and turn to the perpetrator for support and emotional nurturance, and in the process become abused.
- The issue of control is a big factor in spouse and child abusing families. Perpetrators use control to force victims to comply with their wishes.
- Generational boundaries are often unclear between the perpetrator and child victim.
- There is a lack of social contacts outside the family.
- Parents have inadequate coping skills, particularly under stress.
- Family problems become family secrets, therefore not allowing change of intervention to occur within the cycle of violence.
- Substance abuse is sometimes a factor in cases involving domestic violence.

There are specific behavioral indicators of abuse frequently seen in spouses and children who have been abused. Any one of these behaviors may be the victim's way of communicating to the physician or health care professional that something is wrong, that he or she is being abused. A mistake frequently made by health care professionals is that these behaviors are viewed as "the problem", rather than the symptom of a far greater family problem, namely domestic violence. The most prominent physical and behavioral indicators are summarized in Table 2 and address both the child and the spouse. These indicators become important to the counselor in screening for domestic violence in the care pathway.

Table 2

Trauma Accommodation Syndrome:

The trauma of physical and/or psychological abuse for the victim is often a difficult experience to understand and accommodate. The Trauma Accommodation Syndrome (Miller & Veltkamp, 1998) is based on DSM IV criteria (American Psychiatric Association, 1994) and outlines how trauma such as abuse is processed by the victim. There is usually extreme difficulty in discussing any aspect of the victimization. The victim confronted with such abuse often passes through a series of stages in dealing with this trauma. The initial stage is one of victimization, which is recognized as the stressor and is usually realized as an acute physical and/or psychological traumatization. The person's response is usually one of feeling overwhelmed and intimidated, and the locus of control for the victim is more of an external nature. It is not uncommon for the victim to think recurringly of the stressful experience and to focus on the intimidating act, as well as the physical pain associated with the abuse. Figure 3 summarizes the stages or phases the victim often experiences along with clinical indicators present during each stage.

Figure 3

This acute stage of trauma involving feelings of helplessness and fear is followed by a stage involving more cognitive disorganization and confusion. This stage is marked by a vagueness in understanding both the concept of abuse and the expectations associated with the demands of the perpetrator. The third stage may involve denial and a conscious inhibition wherein an effort is made on the part of the victim to actively inhibit thoughts and feelings related to the abuse. This can involve revisiting the cognitive

disorganization phase and the earlier memories, with flashbacks to the acute physical and psychological trauma. This stage can also realize avoidance involving unconscious denial, wherein the victim is not aware of his effort to avoid the psychological trauma associated with the abuse. The victim, therefore, unconsciously denies or minimizes the abuse and/or any efforts to respond to the abusing experiencing. This results in stagnation, feelings of entrapment, and often results in the victim accommodating the pain of the abuse.

This avoidant stage may be followed by a stage of therapeutic reevaluation, where a "significant other" usually supports the reasoning through and the reevaluation of this psychological and physical trauma associated with the abuse. In this stage, the victim may begin to disclose specific content relevant to the abuse. The phase of therapeutic reevaluation and reasoning is significant in that it indicates that conscious support has been realized by the victim in passing from the avoidant phase to the issues, activities, and trauma of the abusing experience(s).

The final stage is one of accommodation which involves coping and/or resolution, wherein the victim has been able to deal with the issues of the abuse and comes to a better understanding of the significance of the abuse and the perpetrator. The victim is viewed at this stage as: (1) being more open to talking about the incident, (2) being able to express thoughts and feelings more readily, and (3) being committed to both assessment and therapy where the victim may discharge some of the aggressive feelings toward the perpetrator. It is clearly at this stage that the victim has realized an alliance with the counselor, significant others and/or other professionals in: (1) exploring the original abusive experience, (2) dealing with both the physical and psychological stressors involved, (3) attending to the repressed material and the process of either conscious inhibition or unconscious denial utilized during the avoidant stage, (4) focusing

on self-understanding, psychological and emotional support of others in comprehending the rationale for the abusing experiences, and (5) exploring appropriate psychosocial lifestyles to determine the degree of therapeutic intervention yet required.

Treatment and Legal Considerations

Counseling of an abused person and/or the perpetrator is a complex process which may involve a multidisciplinary team. Collaboration, cooperation, mutual respect, and understanding of each other's roles are essential to the success of the therapeutic process. The reporting law recognizes the need for open communication in the area of abuse and recognizes no privileged relationships beyond the attorney-client relationship. Siblings must also be addressed in abuse cases. In physical and sexual abuse cases, the siblings have often been exposed to the same family themes as the victim; and in many cases, the siblings may also have been abused. They may also feel guilty that they had not attempted to intervene and stop the abusive pattern. The following are important areas for counselors to address:

(1) Abide by all reporting laws and facilitate appropriate medical care immediately.

(2) Maintain the therapeutic relationship with the victim. The victim's contact with the perpetrator should be monitored. Reducing the degree of environmental change is crucial for children. Maintaining the child's relationship with peers, the school, neighborhood and church, are important to reduce risk of further problems.

(3) Reduce risk for siblings and others by providing suspected or reported information to authorities as identified in state reporting laws.

(4) Refer or evaluate to determine if siblings or other family members are showing signs and symptoms of abuse.

(5) If victim and siblings cannot be protected in their home, they should be removed from the home environment through legal advocacy referral often through the county attorney's office.

Miller and Veltkamp (1998) have summarized the spectrum of community resources available to the counselor and other health care professionals. These include the following:

(1) Safe shelters and 24-hour crisis line: Be aware of services that provide a place where victims and abusers may call anytime, day or night, to receive counseling, information, referrals, and screening for shelter admission.

(2) Counseling and casework services: These services are designed to facilitate the victim's exploration of alternatives to being abused and provide eventual return to the community and a non-explicated or abusive relationship.

(3) Legal advocacy programs: Programs such as these provide a legal advocate to act as a liaison between the victim of domestic violence, whether residing at a shelter or not, and the court system counselor's should work closely with legal advocacy system.

(4) Hospital advocacy program: This service provides a hospital advocate who will meet the victim at the hospital to provide information, support, medical treatment and referrals to other medical and health related professional services.

(5) Perpetrator's Intervention Programs: This service provides perpetrators the opportunity to seek alternatives to violence and break down the isolation they may feel and provide alternatives to physically, psychologically, and sexually abusive behaviors they have likely developed as a part of their behavior pattern.

(6) Community education: Counselors should participate in community education and service programs on issues of domestic violence to improve public awareness of the scope of abuse and family violence in the community.

SUMMARY

In the treatment of family related domestic violence, counselors must be sensitive to a standardized model and response to the needs of individuals who have been victimized through domestic violence. A model algorithm for abuse is summarized herein as is a standardized care pathway that is beneficial to the new paradigms of health care delivery. Counselors, as well as other health care professionals, must understand the transforming paradigms effecting health care service provision through managed care and that practice guidelines are a critical ingredient in today's health care environment.

Counselors should determine the applicability of these evolving concepts to their organizations and evaluate the impact on the quality and continuity of health care delivery with respect to all clinical disorders including the impact of domestic violence on health and adjustment of clients. The algorithm and care pathway generated only provide a framework from which counselors and providers should devise more innovative plans for operationalizing and implementing health care delivery to victims and perpetrators of domestic violence. Success of prevention programs, as well as intervention strategies, will depend on counselors, as health care providers, making fundamental use of standardized models of assessment and intervention in cases of domestic violence.

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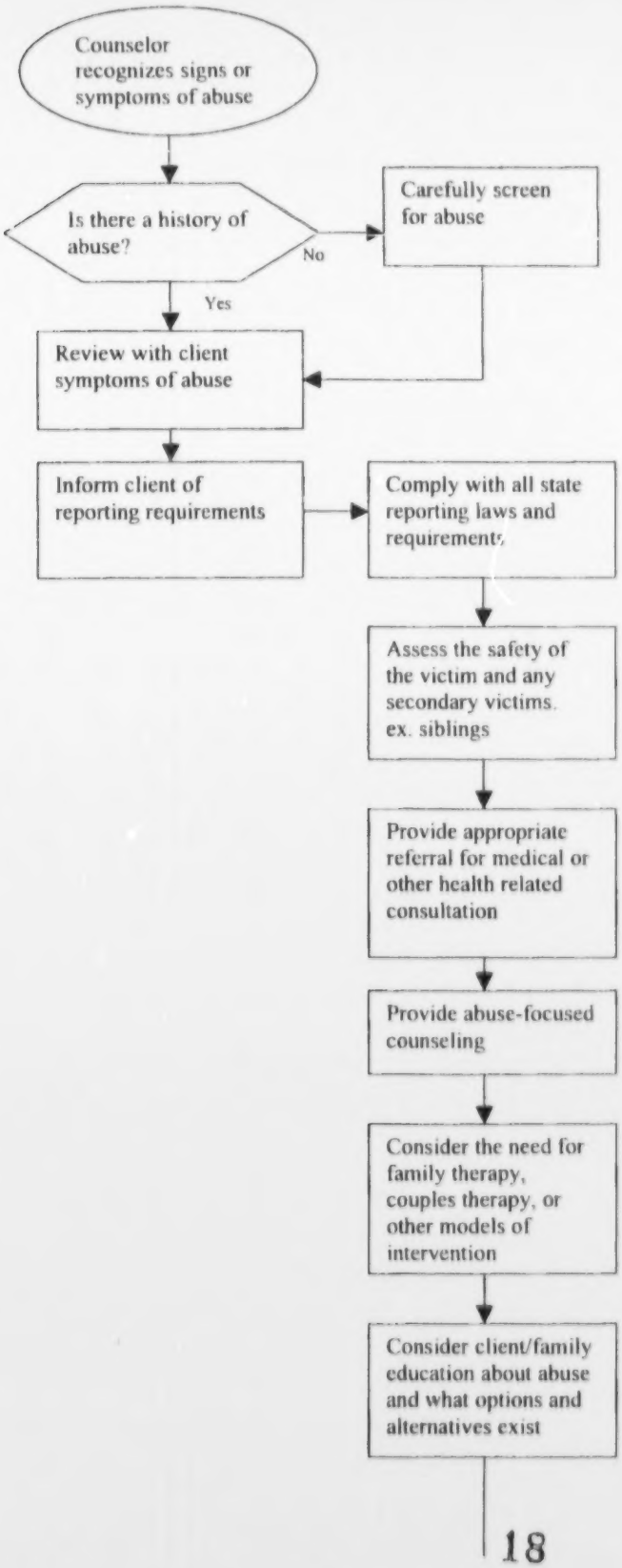
Figure 1 Model Algorithm for Abuse


Counselor recognizes signs or symptoms of abuse
Is there a history of abuse?
No
Yes
Carefully screen for abuse
Review with client symptoms of abuse
Inform client of reporting requirements
Comply with all state reporting laws and requirements
Assess the safety of the victim and any secondary victims. ex. siblings
Provide appropriate referral for medical or other health related consultation
Provide abuse-focused counseling
Consider the need for family therapy, couples therapy, or other models of intervention
Consider client/family education about abuse and what options and alternatives exist

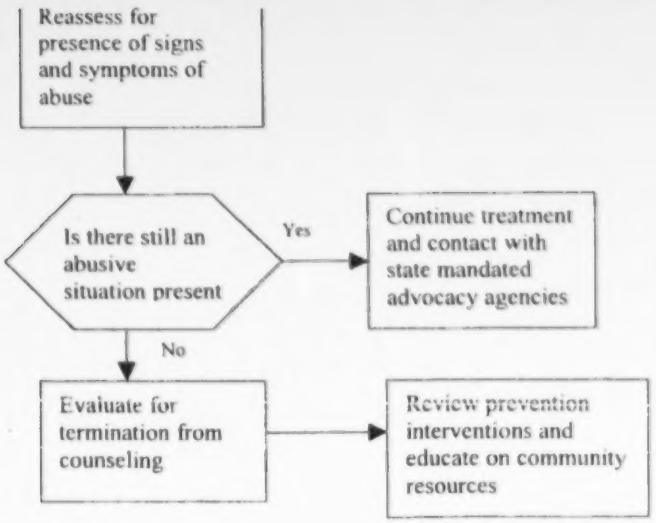

Reassess for presence of signs and symptoms of abuse
Is there still an abusive situation present
Yes
Continue treatment and contact with state mandated advocacy agencies
No
Evaluate for termination from counseling
Review prevention interventions and educate on community resources

FIGURE 2

INTEGRATED SAMPLE CARE
PATHWAY FOR DEPRESSED
CLIENT WITH INDICATORS OF DOMESTIC VIOLENCE
CRITICAL PATHWAY (GUIDELINES) DOMESTIC VIOLENCE

ACTIVITY	VISIT 1	VISIT 2-5	VISIT 6	VISIT 8
ASSESSMENT	Abuse Screening		PRN Assessment	Depression Screening
INTERVENTION	Abide by reporting requirements for abuse in your jurisdiction	Abuse focused Mental Health Counseling Brief Therapy		Considered for Individual Counseling; Family Counseling; Couples Therapy Cultural Specific Holistic Care
CONSULTS/ ASSESSMENTS CONSIDERED	Internist Psychologist Psychiatrist Mental Health Counselor OB/GYN Pediatrician	Follow-up with consultant	Integrate counsel and recommendations	
CLIENT/ FAMILY EDUCATION				Encourage client and family education, review "cycle-violence", theory and encourage victim-initiated interventions and control

TABLE 1: VICTIM-VICTIMIZER SPECTRUM

VICTIM	VICTIMIZER
Isolation from others	History of multi-generational abuse
Feeling of helplessness	Learned violent behavior
Vulnerable	Unstable
Secrecy	Low self-esteem
Indecision	Impulsive
Poor self-confidence	Impaired judgment
Low self-esteem	Narcissistic
Fear, anxiety, depression	Alcohol and/or substance abuse
Impaired ability to judge, trustworthiness in others	Control and power seeking
Accommodates to the victimization	Perpetuates continued forms of victimization

Table 2

Physical and Behavioral Indicators of Family Violence, Sexual Abuse, and Spouse Abuse

FAMILY VIOLENCE

Physical Indicators
Unexplained bruises and welts
Unexplained burns, especially on soles, palms, back or buttocks
Immersion burns
Rope burns on arms, legs, neck or torso
Unexplained fractures to skull, nose, or facial structure; in various stages of healing; multiple or spiral fractures
Unexplained lacerations or abrasions to mouth, lips, gums, eyes, or external genitalia

Behavioral Indicators
Emotional constriction and blunted affect
Fear of adult contacts
Extreme withdrawal or aggressiveness
Extreme rejection or dependence on caretakers
Apprehension, fearfulness
Afraid to go home
Depression
Phobias, anxiety
Sleep disturbance
Withdrawn, inhibited behavior
Obsessive-compulsive behavior

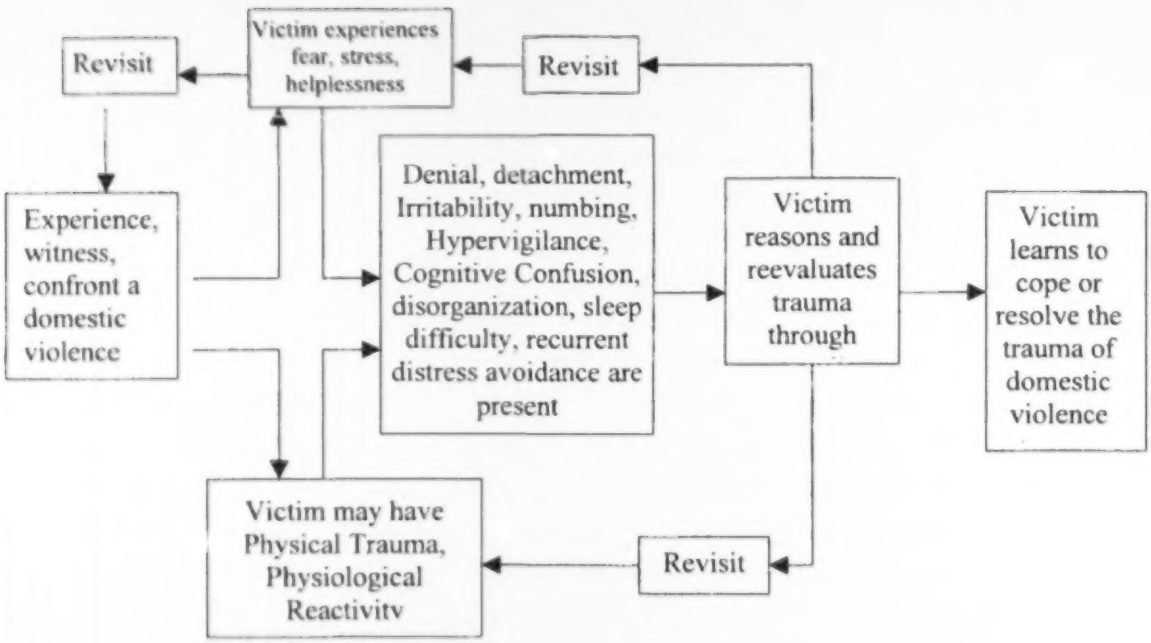
SEXUAL ABUSE

Physical Indicators
Difficulty in walking or sitting
Torn, stained, or bloody underclothing
Bruises or bleeding in external genitalia, vaginal, or anal areas
Venereal disease, especially preteens
Pregnancy

Behavioral Indicators
Sleep disturbances
Withdrawn or regressed behavior
Secondary enuresis or encopresis
Bizarre, sophisticated or unusual sexual behavior or knowledge
Poor interpersonal skills
Self-report of abuse
Anorexia
Extreme self-blame
Extreme fears

Figure 3

TRAUMA ACCOMODATION SYNDROME
(Miller and Veltkamp, 1996)


Victim experiences fear, stress, helplessness
Revisit
Revisit
Experience, witness, confront a domestic violence
Denial, detachment, Irritability, numbing, Hypervigilance, Cognitive Confusion, disorganization, sleep difficulty, recurrent distress avoidance are present
Victim reasons and reevaluates trauma through
Victim learns to cope or resolve the trauma of domestic violence
Victim may have Physical Trauma, Physiological Reactivitv
Revisit

I	II	III	IV	V
Victimization Stage	Acute Trauma Stage	Avoidant Stage	Therapeutic Reevaluation Stage	Accommodation Stage

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